

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031577

FILED VS SEP 28 1959

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

|  |  |   |  |   |  |  |  |  |         |  |
|--|--|---|--|---|--|--|--|--|---------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Carroll</b>                       |  |  |  |  |         |  |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Joseph</b>   |  | Length of stay in 1b<br><b>2 1/2 yrs. 1 mo. 2 wks</b>   |  | c. CITY OR TOWN <b>Carrollton</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |  |         |  |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>State Hosp. #2</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (if outside, give location)                |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |         |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LIZZIE</b> Middle <b>WELLMAN</b> Last <b>WELLMAN</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>12,</b> Year <b>1959</b>  |  |  |  |  |         |  |
| 5. SEX<br><b>female</b>  |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1881</b>  |  | 9. AGE (last birthday) <b>78</b>                       |         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housekeeper</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><b>Carroll County, Mo.</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |  |  |         |  |
| 13a. FATHER'S NAME<br><b>Henry Wellman</b>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Ella Matcher</b>                                     |   |  | 14. NAME OF HUSBAND OR WIFE  |  |  |         |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |  |   | 16. SOCIAL SECURITY NO.<br><b>none</b>   |   | 17. INFORMANT<br><b>State Hosp. Records, St. Joseph, Mo.</b> |  |  |  | Address |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cerebro vascular accident</b><br><b>arteriosclerosis</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <b>hypertension</b> |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 hrs.</b>      |         |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |  |   |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |         |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |  |  |  |  |         |  |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.  |  | Month, Day, Year  |  |   |  |  |  |  |         |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 20f. CITY, TOWN, OR LOCATION  |  | COUNTY   |  | STATE  |         |  |
| 21. I attended the deceased from <b>8:00 am Sept. 12, 1959</b> to <b>4:30 p.m. 9/12/59</b> and last saw her alive on <b>3:30 p.m. 9/12/59</b>  |  |   |  | Death occurred at <b>4:30 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.                                       |  |  |  |  |         |  |
| 22a. SIGNATURE (Degree or title)<br><b>Mohammad Taher M.D.</b>   |  |   |  | 22b. ADDRESS<br><b>State Hosp. #2, St. Joseph, Mo.</b>  |  |  |  | 22c. DATE SIGNED<br><b>9/12/59</b>                     |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>  |  | 23b. DATE<br><b>9/13/1959</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Carrollton, Mo.</b>  |  |  |         |  |
| 24. FUNERAL DIRECTOR<br><b>Heston Brown</b>  |  |   |  | ADDRESS<br><b>St. Joseph, Mo.</b>   |  | 25. DATE RECD. BY LOCAL REG.<br><b>Sept. 18 1959</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Clark Goodell</b> |         |  |

DOCUMENT

MEDICAL CERTIFICATION  
M. Tahir M.D.

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 2010th St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting:

If this body is not embalmed, fact should be so stated above.